Integrated Care Programme

Metrics Framework

This paper will outline the different metrics being used at various levels of the Better Care Fund and integrated care projects. It does not seek to be an exhaustive list and other measures can of course to added at appropriate levels should stakeholders believe it to be beneficial.

Better Care Fund

The Better Care Fund is a pooled budget which funds a collection of services and projects. Some of these services or projects were previously funded by the s256 transfer; others were either council or CCG core funded. The full list is below:

Service	Contribution (£K)
Mental Health Advisors	156
7 Day Service	500
Falls Service (ASC & PH)	528
Stroke Advisors	140
Hospital Discharge Teams	791
Quality in Care Team	310
MAGs	90
Reablement	2172
Home from Hospital	222
Equipment & Telecare	306
Carers	550
Self funder support	395
Risk Reserve - placements	600
Risk Reserve – urgent care	739
Risk Reserve – other	161
Adult Community Healthcare Teams	13131
Community in-patient services	4205
IV therapy & OPAT services	59
DFG	1499
Social Care Capital Grant	931
Care Bill	1400
Total	**28,885**

Each of these services or projects is already in existence and therefore has metrics and performance management regimes in place.

The national expectation is that the BCF (by virtue of commissioning new services from the pooled budget) will deliver improvements in a variety of system wide measures for which therefore targets have been set.

The measures were nationally mandated but in the main the targets were locally set. The exception relates to non elective admissions where the national expectation was that all systems would achieve a 3.6% reduction. In Buckinghamshire it was argued that given existing high performance in this area the opportunity for this scale of reduction did not exist and therefore a 1.6% reduction (in real terms, holding flat) would be aimed for.

These metrics are high level and system wide and whilst it is expected that all the BCF projects and services would either directly or indirectly impact on their achievement, attributing any specific change to any specific service or project is likely to only be possible subjectively.

As more services are remodelled in light of the new commissioning arrangements through the BCF it is anticipated that greater impact will be seen.

BCF Template Measures

Measure		2015/16	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	YTD
Rate of emergency admissions	Target	7996	652	652	652	672	672	672	679	679	679	660	660	660	
	Actual														
Permanent admissions to care homes	Target	697													
	Actual	533													
Reablement (proportion still at home after 91 days)	Target	86%													
	Actual	72%													
Delayed transfers of care	Target	1869	156	156	156	156	156	156	156	156	156	155	155	155	
	Actual														
Patient Experience (social care)	Target	0.7													
	Actual														
Patient Experience (acute care)	Target	95													
	Actual														
Patients >65 discharged to the same address	Target	TBC													
	Actual														
Occupied bed days	Target	TBC													
	Actual														

Frail Elderly Service Integration

This is the one area where the creation of the BCF has already facilitated new ways of working across services. In the first instance priority has been given to aligning the existing reablement services operated by Bucks Care and BHT.

The individual services continue to measure their performance and then the single point of referral is also monitoring the outcome of calls made to it.

The BRAVO single point of referral is currently measuring:

- Number of patients referred, by whom and from where
- Number of patients requiring support for admission avoidance or discharge
- Outcome of the referral ie service provided and by which element (s)

The ACHT then measures a variety of things such as:

- Number of visits
- Referrals for ongoing care

Buckinghamshire Care Reablement service also measures a range of things including:

- Average number of hours for each discharged client
- Ongoing care need
- Time from referral to first visit

The success measures for the remodelled service will be finalised at the Integrated Care Programme Board on 17th June but are likely to include:

1. Proportion of patients for admission avoidance rather than discharge
2. Number of patients requiring ongoing care

Below is a draft template with some figures for May to demonstrate the way in which reporting will be undertaken following agreement by the Integrated Care Programme Board at their meeting on 17th June.

SERVICE	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
BRAVO												
No referrals		116										
GPs		96										
Hospital wards		5										
SMH A&E (incl REACT)		15										
Service Response												
ACHT		52%										
Bucks Care		23%										
Joint service		7%										
Person declined service		13%										
Not suitable for reablement		3%										
No admitted to hospital		1										
Bucks Care Reablement												
No clients started		99										
No clients in service on 1st mth		121										
No clients in service on last mth		145										
Visits undertaken		6385										
People requiring less support		77%										
No admitted to hospital		18										
ACHT												
No referrals												
Visits undertaken												
Outcome												
Independent												
Referred for ongoing care												
Admitted to hospital												